



STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH & HUMAN RESOURCES

Earl Ray Tomblin
Governor

Bureau for Behavioral Health and Health Facilities
350 Capitol Street, Room 350
Charleston, West Virginia 25301
Telephone: (877) 215-2522 Fax: (304) 558-3275

Michael J. Lewis, M.D., Ph.D.
Cabinet Secretary

INTERSTATE DUI TRANSFER FORM

SECTION I:

Date: _____

Referring Agency: WV DHHR/DUI Unit _____ Receiving Agency: _____

Referral's Name: (Last, First, MI) _____

Social Security Number: ***-**-**** Date of birth: _____

West Virginia Driver's License #: ID _____

Division of Motor Vehicles' DUI File #: _____

Address: _____ (H)
_____ (W)

SECTION II:

(To be completed by WV BHHF staff only)

Date of DUI Arrest/Conviction: _____ B.A.C. _____

Prior DUI Arrest/Incident/Conviction: _____ Date(s), if available _____

Other convictions: _____ Date(s), if available: _____

SECTION III:

(To be completed by out of state provider/evaluator completing assessment/programming)

Services Recommended at Assessment: _____

Services Completed at Time of Transfer, if applicable: _____

Special Conditions: _____

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Completion Status:

*Initial Enrollment/Evaluation/Assessment Date: _____

Other: _____

*Educational Component (18 hours) Date: _____

*Educational Component/Reassessment (19 hours) Date: _____

***Intervention/Intensive Treatment Component(s) (if applicable, based on assessment) (Clinically indicated for multiple/habitual offense DUI and/or B.A.C. at or above .15)**

Date: _____

*Participation in Alcohol Test and Lock Device Program, if applicable Date: _____

*Attach appropriate documentation including signed Consent for Release of Information, 42 C.F.R. Part II, as applicable.

(To be completed by the clinician/provider/director/programmer)

For additional information contact: (Name) _____

Address: _____

Telephone Number: _____

Signature/Title: _____ Date: _____

TO BE COMPLETED BY WVDHHR – BHHF STAFF ONLY - SECTION IV:

Reviewed for approval:

Name(print): _____ Signature: _____ Date: _____

Approved for forward to WV-DMV offices for processing:

Name(print): _____ Signature: _____ Date: _____

(RETAIN A COPY OF COMPLETED FORM FOR THE CLINICAL RECORD)

UPON THE CLIENT'S COMPLETION OF ALL RECOMMENDED SERVICES OF IF NON COMPLIANT,

THE COMPLETED FORM DIRECTLY TO:

**DUI COORDINATOR
WEST VIRGINIA DUI SAFETY AND TREATMENT PROGRAM
BUREAU FOR BEHAVIORAL HEALTH AND HEALTH FACILITIES
350 CAPITOL STREET, ROOM 350
CHARLESTON, WEST VIRGINIA 25301-3702**

